DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1942

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10005

Primary Registration District No. 1

Registrar's No. 107

1. PLACE OF DEATH:

(a) County: Adair

(b) City or town: Kirksville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Community Nursing Home (If not in hospital or institution, write street number or location) 4 1

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community: 47 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Shelby 10.2

(c) City or town: Leonard (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: William G. Vandiver

3. (b) If veteran, name war: No.

3. (c) Social Security No.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Helen Frances Vandiver

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Jan. (Month) 19 (Day) 1865 (Year)

8. AGE: Years 77 Months 2 Days 14 If less than one day hr. min.

9. Birthplace: Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Carpenter

11. Industry or business:

MOTHER FATHER

12. Name: William A. Vandiver

13. Birthplace: Not known (City, town, or county) (State or foreign country)

14. Maiden name: Virginia Triplett

15. Birthplace: Not known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Stacey Vandiver

(b) Address: Shelbyville - Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr - 5 - 42 (Month) (Day) (Year)

(c) Place: burial or cremation: Shelbina - Mo

18. (a) Signature of funeral director: Mellon & Barpelow

(b) Address: Shelbina - Mo

19. (a) April 4, 1942 (Date received local registrar) (b) Mrs. J. F. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd year 1942 hour 3 minute 25 P. M.

21. I hereby certify that I attended the deceased from Feburary 15, 1942, to April 3rd, 1942; that I last saw him alive on April 3rd, 1942; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	3 dys
Due to Chronic Myocarditis & Chronic Endocarditis	
Due to	
Other conditions (Include pregnancy within 3 months of death) Arterio-sclerosis	
Gangrene	

Major findings: Of operations: No operation

Of autopsy: No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Richard G. Noble (M. D. or other) MD

Address: Kirksville, Mo Date signed: 4/3/42

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19811

RECEIVED
District Health Officer No. 10
District File Number 11-10-791
Date Filed APR 15 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Registered Apprentice No. ....., working under my personal supervision.

Signed E. M. Hawkins

Licensed Embalmer No. 2498

P. O. Address Bethel - Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
10M 2-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10005

Registration District No. 1 Primary Registration District No. 1 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Gasconade
(b) City or town: Gerkeville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William G. Vandiver
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Jan (Month) 19 (Day) 1865 (Year)
8. AGE: Years 77 Months 2 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia — Duration
Due to
Due to: Bronchial Pneumonia
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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